STATE OF WISCONSIN

FACT SHEET ON MANDATED BENEFITS FOR THE TREATMENT OF NERVOUS AND MENTAL DISORDERS, ALCOHOLISM, AND OTHER DRUG ABUSE

OFFICE OF THE COMMISSIONER OF INSURANCE PI-008 (R 10/2003)

The Wisconsin Office of the Commissioner of Insurance has prepared this guide to assist health care providers and insurers in understanding and applying Wisconsin's mandated health care benefits law, as it relates to the treatment of nervous and mental disorders, alcoholism, and other drug abuse. This guide also discusses the federal Mental Health Parity Act of 1996.

Please refer questions to:

Health Services Section
Quality Assurance - DHFS
2917 International Lane
Madison, Wisconsin 53704
(608) 243-2024 Phone
(608) 243-2026 Fax

or

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873
(608) 266-0103 (In Madison)
1-800-236-8517 (statewide)

Wisconsin law requires that certain group health insurance policies include inpatient, outpatient, and transitional benefits to treat nervous and mental disorders, alcoholism, and other drug abuse problems. [s. 632.89, Wis. Stat.]

Q. To what policies or plans does the law apply?

A. This law applies only to group insurance policies and contracts issued in Wisconsin and to comparable policies issued to a group based in another state if more than 25% of the insured persons are Wisconsin residents.

These mandated benefits are not required in:

- Individual insurance policies;
- Federal employee group plans (e.g., postal carrier's plans);
- Self-insured employer group plans falling within the terms of the federal Employee Retirement Income Security Act (ERISA) of 1974;
- Self-insured counties, municipalities, or school districts;
- Most policies issued to a group based in another state if both the policyholder and group exist primarily for purposes other than to procure insurance and fewer than 25% of the insured persons are Wisconsin residents; and
- Health maintenance organizations (HMOs) and limited service health organizations (LSHOs) formed as cooperatives under ch. 185, Wis. Stat.

Q. What services are covered by the law?

A. There are three services covered by the law:

- *Inpatient Services.* These are services for the treatment of nervous and mental disorders or alcoholism and other drug abuse problems that are provided to a bed patient in a hospital.
- *Outpatient Services.* These are nonresidential services for the treatment of nervous and mental disorders or

alcoholism or other drug abuse problems that are provided to an insured by any of the following entities or persons or, if for the purpose of enhancing the treatment of the insured, a collateral of the insured.

- A program in an outpatient treatment facility that has been approved by the Department of Health and Family Services and established and maintained according to rules promulgated under s. 51.42 (12), Wis. Stat.

- A licensed physician who has completed a residency in psychiatry in an outpatient treatment facility or in the physician's office.

- A licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or who is certified by the American Board of Professional Psychology.

- *Transitional Treatment Services.* These are services for the treatment of nervous or mental disorders or alcoholism or other drug abuse problems that are provided to an insured in a less restrictive manner than are inpatient hospital services but in a more intensive manner than are outpatient services.

Q. Must all plans and policies to which the law applies provide both inpatient and outpatient services?

A. No. Group plans that provide only inpatient hospital treatment coverage are required to provide coverage for inpatient hospital treatment and transitional treatment.

Group plans that provide only outpatient treatment coverage are required to cover outpatient services and transitional treatment services.

A group policy that covers both inpatient and outpatient treatment for any condition other than those covered by the mandates must provide coverage for inpatient, outpatient, and transitional treatment services.

Q. What types of coverage must be provided in plans subject to the law?

A. Required coverages are for the treatment of nervous and mental disorders, alcoholism, and other drug abuse problems.

Q. What is the minimum coverage that must be provided in every policy year?

A. A group policy that provides coverage for inpatient hospital services must cover:

- At least expenses for the first 30 days as an inpatient in a hospital; or

- At least $7,000 for inpatient services minus any cost-sharing amounts (deductibles, copayments, or coinsurance) at the level charged under the policy for other inpatient treatment services or the equivalent benefit measured in services rendered (number of days or visits). If a policy does not use cost-sharing, it is $6,300 in equivalent benefits measured in services rendered.

- At least $3,000 for transitional treatment minus any cost-sharing amounts (deductibles, copayments, or coinsurance) at the level charged under the policy for other transitional treatment services or the equivalent benefit measured in services rendered (number of days or visits). If a policy does not use cost-sharing, it is $2,700 in equivalent benefits measured in services rendered.

A group policy that provides coverage for outpatient services must cover:

- At least $2,000 of services for outpatient services minus any cost-sharing amounts (deductibles, copayments, or coinsurance) at the level charged under the policy for other outpatient treatment services or the equivalent benefit measured in services rendered (number of days or visits); or

- If a policy does not use cost-sharing, it is at least $1,800 in equivalent benefits measured in services rendered.

- At least $3,000 for transitional treatment minus any cost-sharing amounts (deductibles, copayments, or coinsurance) at the level charged under the policy for other transitional treatment services or the equivalent benefit measured in services rendered (number of days or visits). If a

policy does use cost-sharing, it is at least $2,700 for equivalent benefits measured in services rendered.

However, total coverage for inpatient, outpatient, and transitional treatment services need not exceed $7,000 or equivalent benefits if provided by an HMO or LSHO.

Q. Do copayment requirements and deductibles of the policy apply to these mandated benefits?

A. An insurer may apply the same deductible amount and/or copayment amount to mental health and alcoholism and other drug abuse services that apply to all other benefits.

Q. Outpatient services will cover treatment provided to a collateral if the treatment was rendered for the purpose of enhancing the treatment to the insured. What is the meaning of a "collateral"?

A. A "collateral" means a member of an insured's immediate family and is limited to the spouse, children, parents, grandparents, brothers, and sisters of the insured and their spouses.

Q. Some group policies set waiting periods for preexisting conditions. How is the date of onset of the nervous or mental disorder, alcoholism, or drug abuse condition to be determined to judge whether the condition is a preexisting condition for insurance purposes?

A. An insurer may apply a waiting period for a preexisting condition if it has evidence that the disease existed prior to coverage under the policy. Sufficient evidence would be a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period prior to enrollment in the health plan.

Q. May benefits be paid under more than one plan?

A. Benefits can be paid under more than one plan. However, most group plans contain a coordination (or duplication) of benefits provision that is intended to limit the payment of benefits under all coverage to 100% of the total covered expenses.

Q. Does the requirement for coverage of outpatient treatment prohibit any limitation on the amount of a provider's charge to be covered, e.g., application of a "usual and customary fees" limitation that would be generally applicable to other covered conditions?

A. No, if the basis an insurer uses to establish fee reimbursement levels is reasonable and equitably applied to all providers.

Q. Are prescription drugs included as part of the mandated coverage for the treatment of nervous and mental disorders, alcoholism, and other drug abuse?

A. Yes, prescription drugs are covered if the drugs are prescribed for a patient who is receiving treatment on either an inpatient or outpatient basis and if the prescription drugs are for the treatment of nervous and mental disorders, alcoholism, or other drug abuse problems. The costs incurred for the prescription drugs can be applied toward the minimum coverage for either inpatient or outpatient treatment, depending upon if the patient is an inpatient or an outpatient.

Q. When did this law become effective? Does it apply to policies and contracts then in force or only to those issued after that date?

A. This law first became effective July 20, 1985. Increased benefits for outpatient treatment was effective for policies issued or renewed after May 12, 1992. Coverage for transitional treatment applies to policies issued or renewed on or after November 1, 1992.

The Mental Health Parity Act of 1996—A Federal Law

Q. What is the Mental Health Parity Act of 1996?

A. The federal Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. MHPA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. MHPA's provisions

are subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services.

Q. How will the Mental Health Parity Act affect mental health benefits?

A. Under MHPA, group health plans, insurance companies, and HMOs offering mental health benefits will no longer be allowed to set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical and surgical benefits. A plan that does not impose an annual or lifetime dollar limit on medical and surgical benefits may not impose such a dollar limit on mental health benefits offered under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

Q. Do these requirements apply to all group health plans?

A. No. Health plans are not required to include mental health in their benefits package. The requirements under MHPA apply only to plans offering mental health benefits.

Q. May an insurer impose restrictions on mental health benefits?

A. Yes, insurers will be able to set the terms and conditions including cost sharing and limits on the number of visits or days of coverage, for the amount, duration, and scope of mental health benefits.

Q. Do all group health plans offering mental health benefits have to meet the parity requirements?

A. No. There are two exceptions to these new rules.

- The mental health parity requirements do not apply to small employers who have fewer than 51 employees.
- Any group health plan whose costs increase 1% or more due to the application of MHPA's requirements may claim an exemption from MHPA's requirements.

Q. When did this law become effective?

A. The mental health parity requirements apply to group health plans for plan years beginning on or after January 1, 1998. Plans that have calendar year plan years or plan years that otherwise begin early in 1998 were provided a transition period until March 31, 1998.

Under MHPA, there is also a "sunset" provision in the law requiring that the requirements under MHPA will cease to apply to benefits for services furnished on or after September 31, 2001.

If a provider or patient has a question about whether a claim for insurance benefits has been handled properly, contact the Office of the Commissioner of Insurance describing the problem. Include the name of the insurance company, the group policy number, and the subscriber or certificate number. Send complaint to:

Information and Complaints Section
Office of the Commissioner of Insurance (OCI)
P. O. Box 7873
Madison, WI 53707-7873
(608) 266-0103 (In Madison)
1-800-236-8517 (Outside Madison)

How to Find Out More

If you have additional questions regarding the federal Mental Health Parity Act, please contact:

Employee Benefits Security Administration
(EBSA)
U.S. Department of Labor (DOL)
200 Constitution Avenue, N.W.
Washington, DC 20210
1-866-4-USA-DOL (1-866-487-2365)
1-877-889-5627 TTY
http://www.dol.gov/dol/topic/health-plans/

For information on how to file insurance complaints call:

(608) 266-0103 (Madison)
or
1-800-236-8517 (statewide)

Mailing Address
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

Electronic Mail
information@oci.state.wi.us
(please indicate your name, phone number, and e-mail address)

OCI's World Wide Web Home Page
http://oci.wi.gov

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